

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10115
10113 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>James Quarter</u>	LENGTH OF STAY (in this place) <u>1 year</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>James Quarter</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>LAURA</u>	(Middle)	(Last) <u>ABBOTT</u>	DATE: <u>OCT. 12 1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Sept 21-1887</u>
9. AGE last birthday <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Household</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Household</u>	
11. BIRTHPLACE (State or foreign country): <u>Deal Island Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>WILLIAM DIZE</u>		14. MOTHER'S MAIDEN NAME: <u>REBECCA SADDLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Mrs Allen Webster - James Quarter</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>332X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Cerebral Thrombosis</u>			<u>6 weeks.</u>
(B) <u>Generalized Arteriosclerosis</u>			<u>years.</u>
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>NONE</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED (White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>Oct. 12 1955</u> , that I last saw the deceased alive on <u>Oct 11, 1955</u> and that death occurred at <u>6A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Everett C. Sutter</u>		M. D. <u>James Quarter Md. 10-13-55</u>	
23. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>10-14-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		LOCATION (City, town, or county) (State) <u>Deal Island Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/22/55</u>		REGISTRAR'S SIGNATURE <u>Lela J. Whalley</u>	
24. FUNERAL DIRECTOR <u>Lela J. Whalley</u>		ADDRESS <u>Deal Island Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

COMMUNICATIONS SECTION

BUREAU V. S.

1955

RECEIVED

10114

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Virginia		COUNTY Accomack	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crisfield		5 days		TOWNSHIP Tangier Island 83 X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
79 McCready Hospital							
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) HOMER		(Middle) LEWIS		(Last) CROCKETT		(Month) (Day) (Year)	
(Type or Print)						October 2 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Male		Colored		Married		January 21, 1890	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
65 yrs.		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Waterman				Seafood Industry		Tangier Island, Va.	
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Elisha Crockett				unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No							
17. INFORMANT & ADDRESS:				Mrs. Etta Parks Crockett--Tangier, Va.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) acute dil. of heart						1 hour.	
ANTECEDENT CAUSE (S) DUE TO (B) Myocarditis, chronic.						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertensive cardio-vascular disease						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 27, 1955, to Oct. 2, 1955, that I last saw the deceased alive on Oct. 2, 1955, and that death occurred at 2:30 A. M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
C. Rawley		Crisfield Md.		Oct. 3, 1955			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 4, 1955		Swain Memorial Cemetery		Tangier, Va.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Oct. 3, 1955		Barbara S. Adams		Bradshaw & Sons--Crisfield, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 10 1955

RECEIVED

10109

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
39 TOWN <u>Crisfield</u>		1948		OR TOWN <u>Marion Station</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 Sackertown Rd.				I			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>LORETTA</u>		(Middle) <u>B.</u>		(Last) <u>DRYDEN</u>		OF DEATH: <u>October 18 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	widowed	March 10, 1885	70 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				11. BIRTHPLACE (State or foreign country):			
Housewife				Fairmount, Md. USA			
10B. KIND OF BUSINESS OR INDUSTRY:				12. CITIZEN OF WHAT COUNTRY?			
At home				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John S. Blake				Laura Ward			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				none			
17. INFORMANT & ADDRESS:							
Blake Dryden-Sackertown Rd.-Crisfield, Md.							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>							One day
ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerotic Heart Disease</u>							3 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Recurrent Cerebral Embolopathy</u>							3 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:							20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>8/23</u> , 1952, to <u>10/18</u> , 1955, that I last saw the deceased alive on <u>10/17</u> , 1955, and that death occurred at <u>12:20</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>G. N. Barr, M.D.</u>				ADDRESS <u>Crisfield, Md.</u>		DATE SIGNED <u>10/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 20, 1955		St. Paul's Cemetery		Marion Station, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Oct. 20, 1955		<u>Barbara L. Adams</u>		Bradshaw & Sons-Crisfield, Md.			

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 31 1953

BUREAU V. S.

10115

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crisfield		2 hours		TOWN Dames Quarter		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
79 McCready Hospital							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) INFANT		(Middle) BOY		(Last) FORD		OF DEATH: October 19 1955	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: October 19, 1955	
				9. AGE last birthday: 0 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none				10B. KIND OF BUSINESS OR INDUSTRY: none		11. BIRTHPLACE (State or foreign country): Crisfield, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: Joseph Ford				14. MOTHER'S MAIDEN NAME: Lorraine Bozman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS: Joseph Ford--Dames Quarter, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
761.5 IMMEDIATE CAUSE (A) Premature infant						5 1/2 - 6 mo	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Premature Separation, Placenta							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 19, 1955, to Oct. 19, 1955, that I last saw the deceased alive on Oct. 19, 1955, and that death occurred at 11:30 PM, from the causes and on the date stated above.							
SIGNATURE C. Hawley		M. D.		ADDRESS Crisfield, Md.		DATE SIGNED 10/19/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 20, 1955		NAME OF CEMETERY OR CREMATORY Dames Quarter Cemetery		LOCATION (City, town, or county) (State) Dames Quarter, Md.	
DATE REC'D BY LOCAL REGISTRAR Oct. 20, 1955		REGISTRAR'S SIGNATURE Barbara L. Adams		24. FUNERAL DIRECTOR Leroy G. Webster-Deal Island, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING I

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 31 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10119
10110 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Somerset	MARYLAND	STATE Maryland	COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) 39 OR TOWN Crisfield	LENGTH OF STAY (In this place) 20 years	CITY (If outside corporate limits, write RURAL and give nearest town) 39 OR TOWN Crisfield	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 N. 7th St.		STREET ADDRESS (If rural give location) N. 7th St.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) EDITH	(Middle) DENNIS	(Last) GALE	(Month) October 3 (Year) 19 55
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: June 12, 1890
		9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer		10B. KIND OF BUSINESS OR INDUSTRY: Seafood Industry	
11. BIRTHPLACE (State or foreign country): Marion Station, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Arza Dennis		14. MOTHER'S MAIDEN NAME: Mary Whittington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY No. 217-03-0842	
		17. INFORMANT & ADDRESS: Linwood Gale--N. 7th St.--Crisfield, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331 X IMMEDIATE CAUSE (A) Cerebro-Vascular Accident			one day
ANTECEDENT CAUSE (B) Generalized Atherosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertension			18 mo.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-8, 1954, to 10-3, 1955, that I last saw the deceased alive on 10-3, 1955, and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
SIGNATURE Q. N. Barr, M.D.		ADDRESS M. O. Crisfield, Md.	
DATE SIGNED 10-6-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 6, 1955	
NAME OF CEMETERY OR CREMATORY Private Family Cemetery		LOCATION (City, town, or county) (State) Marion Station, Md.	
DATE REC'D BY LOCAL REGISTRAR Oct. 6, 1955		REGISTRAR'S SIGNATURE Barbara S. Adams	
24. FUNERAL DIRECTOR Bradshaw & Sons--Crisfield, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 31

OCT 10 1955

RECEIVED

10111

CERTIFICATE OF DEATH

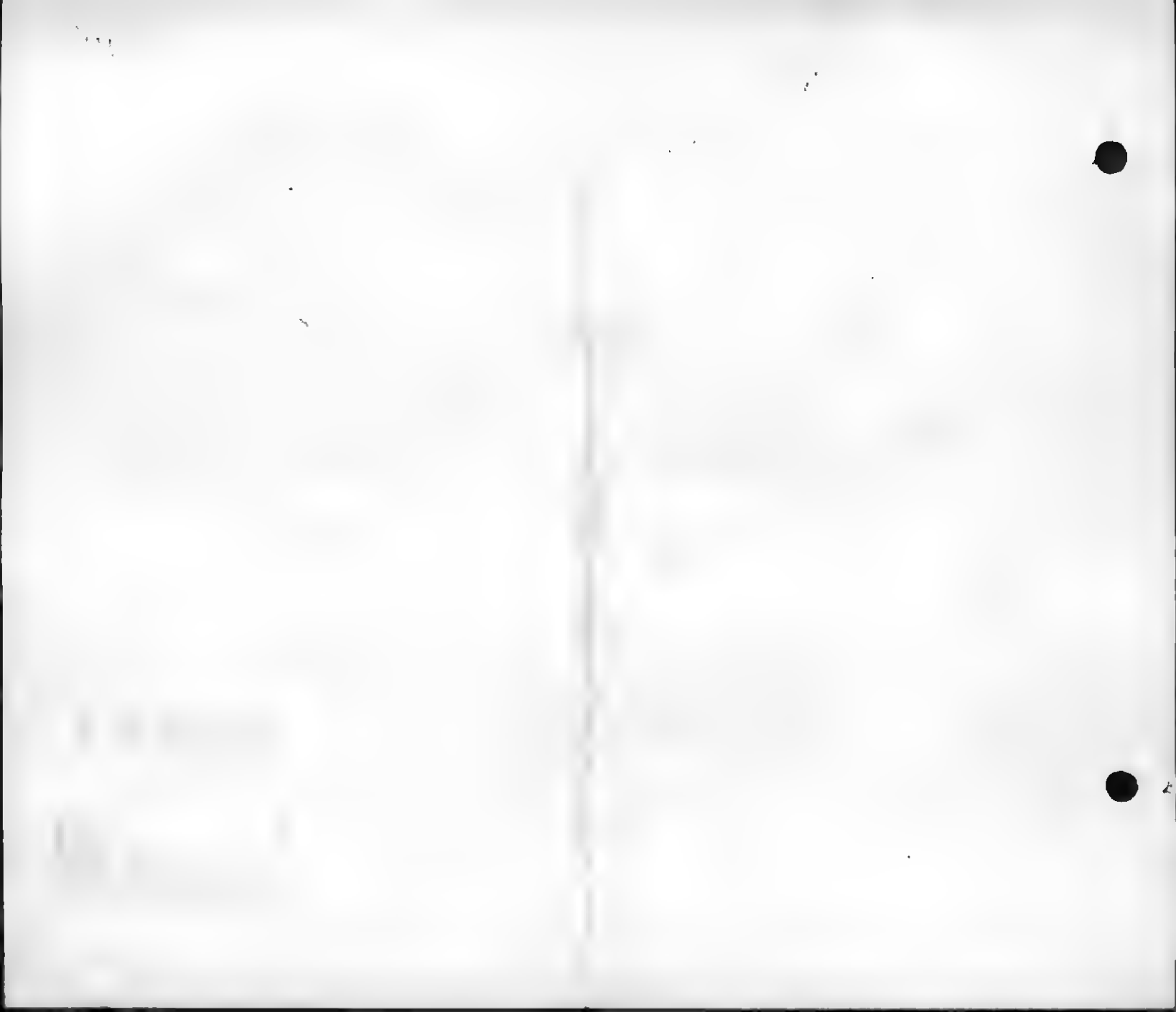
Reg. Dist. No. 263

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brisfield</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brisfield</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>Barnelius</u> (Middle) <u>Hall</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>oct</u> <u>10</u> 19 <u>55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married mar</u>		8. DATE OF BIRTH: <u>22-1881</u>	
9. AGE last birthday: <u>74</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>for white rail dealer</u>		11. BIRTHPLACE (State or foreign country): <u>Accomac Va</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Handy Hall</u>				14. MOTHER'S MAIDEN NAME: <u>Georganne Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-03-8765</u>		17. INFORMANT & ADDRESS: <u>Annie Hall Brisfield Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Abdominal and Osseous Metastasis</u>						1 year	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Carcinoma of the Prostate</u>						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Oct. 1952</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of the Prostate (Philadelphia General Hospital)</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 2, 1955</u> , to <u>10/10, 1955</u> , that I last saw the deceased alive on <u>10-6, 1955</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>A. N. Barr</u>		ADDRESS <u>M. D. Cuyler, Md.</u>		DATE SIGNED <u>10/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 13-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Lanstonia</u>		LOCATION (City, town, or county) (State) <u>Brisfield Somerset Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-13-55</u>		REGISTRAR'S SIGNATURE <u>Robert A. Adams</u>		24. FUNERAL DIRECTOR <u>Charles H. Ward</u>		ADDRESS <u>Marion St Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 -- 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				10121
Item 21f Film G187 10-14-55 ^{ans}				
10116				CERTIFICATE OF DEATH
Reg. Dist. No. 200				
1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Somerset	MARYLAND	STATE Florida	COUNTY Highland	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
X TOWN Crisfield	dead on arrival	OR TOWN Avon Park	48 X - 5	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		
99 McCready Hospital		400 Green St.		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		
THOMAS HARRIS		OF DEATH October 2 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday (If UNDER 1 YEAR, Months Days Hours Min.)
Male	Colored	Married	August 1892	63 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
foreman		Farming	Birmingham, Alabama	USA
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:		
unknown		unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
no		263-26-0154	1745 Master St. Camden, N. J.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
IMMEDIATE CAUSE (A) <u>Pistol Shot wound in Chest</u>				
ANTECEDENT CAUSE (B) <u>See Report of Autopsy</u>				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				
(C) <u>DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, Md.</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, <u>farm</u> , factory, of INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
			<u>Rehoboth Somerset Md</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	21F. HOW DID INJURY OCCUR? <u>HOMICIDE</u>	
<u>10 2 1955-AM</u>			<u>A Shot in Chest with Pistol</u>	
22. I hereby certify that I attended the deceased from <u>He was dead before</u> and that death occurred at <u>11 A. M.</u> from the causes and on the date stated above.				
SIGNATURE <u>Wm H Coulbourn</u>		ADDRESS <u>Crisfield Md</u>		DATE SIGNED <u>Oct 5-1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)	
Burial	Oct. 10, 1955	Avon Park Cemetery	Avon Park, Florida	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>10-5-55</u>	<u>T. H. Jones</u>	<u>Bradshaw & Sons Funeral Home—Crisfield, Md.</u>		

CHILAU V

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10117

CERTIFICATE OF DEATH

11222

Reg. Dist. No. 261

1. PLACE OF DEATH COUNTY <u>Somerset</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marion Station</u> LENGTH OF STAY (in this place) <u>87 yrs.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Somerset</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marion Station</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George William Horsey</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 31 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 1, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Marion Sta., Somerset Co.</u>
13. FATHER'S NAME <u>John Horsey</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Banks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>220-26-3211</u>	17. INFORMANT & ADDRESS <u>Arzey T. Horsey 820 Palm St. Philadelphia, Pa.</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X IMMEDIATE CAUSE (A) <u>infection</u></u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>Hypertensive Arteriosclerotic Cardio-Vascular Disease</u> <u>Senility</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u> <u>Sen. Bron.</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>Senility</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 20, 1954</u> , to <u>Oct 31, 1955</u> , that I last saw the deceased alive on <u>10/22, 1955</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Q. H. Bann</u>		DATE SIGNED <u>11/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATOR <u>Branch Liberia</u>	
DATE THEREOF <u>Nov. 3, 1955</u>		LOCATION (City, town, or county) (State) <u>Marion Station Md.</u>	
24. REC'D BY REGISTRAR DATE <u>11-9-55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>	
REGISTRAR'S SIGNATURE		ADDRESS <u>Marion Sta., Md.</u>	

Box 235



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10118

CERTIFICATE OF DEATH

10122

Reg. Dist. No. 261

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Somerset</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Marion Station</i>				TOWN <i>Marion Station</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Adeline</i> (Middle) <i>Lankford</i> (Last)				(Month) <i>Oct.</i> (Day) <i>29</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>Col.</i>	<i>Widowed</i>	<i>March 14, 1874</i>	<i>76</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Domestic</i>				<i>Marion Station.</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John Small</i>				<i>Mickey Henry</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
<i>No</i>				<i>Costella Whittington, Marion Sta.</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
434.3 IMMEDIATE CAUSE (A) <i>Acute dilatation of heart</i>							
ANTECEDENT CAUSE(S) DUE TO <i>Haemia & Anasarca</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Rheumatoid arthritis</i>							
12 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 29</i> , 19 <i>55</i> , to <i>Oct 29</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Oct 29</i> , 19 <i>55</i> , and that death occurred at <i>11 A.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>C. K. Kaulley</i>				ADDRESS (Street, city, town, state) <i>Crisfield, Md.</i>		DATE SIGNED	
				M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Nov. 1, 1955</i>		<i>John Wesley</i>		<i>Marion Sta., Som. Co. Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<i>Nellie D. Payne</i>		<i>Charles H. Ward</i>		<i>Marion Sta., Md.</i>	
DATE							

Md. For 23



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10123
10119 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH: COUNTY <u>Somerset</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> TOWN <u>Crisfield</u> LENGTH OF STAY (in this place) <u>1 week</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> OR TOWN <u>Pocomoke</u> 23X-2 STREET ADDRESS (If rural give location) <u>RFD #3</u>	
3. NAME OF DECEASED: (First) <u>G.</u> (Middle) <u>RUFUS</u> (Last) <u>MASON</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct 16,</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>March 2, 1878</u>
9. AGE last birthday <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u>	11. IF UNDER 24 HRS. Hours <u>77</u> Min. <u>77</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George L. Mason</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Ellen Dickerson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <u>No</u> (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Clara R. Mason, Pocomoke, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>260X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (A) <u>Thrombosis Acute Dil. of Heart</u> DUE TO (B) <u>Chronic Myocarditis + Chronic Lat. Nephritis + Diabetes mellitus</u> DUE TO (C)			<u>10 days</u> <u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY OCCUR?	
21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 9, 1955</u> , to <u>Oct 16, 1955</u> , that I last saw the deceased alive on <u>Oct. 16, 1955</u> , and that death occurred at <u>3:50P</u> M, from the causes and on the date stated above. SIGNATURE <u>Henry C. Cochran</u> ADDRESS <u>Marion Sta. Md.</u> DATE SIGNED <u>Oct. 18, 1955</u> M.D. <u>Marion Sta. Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/19/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Hellie D. Payne</u>	
24. FUNERAL DIRECTOR <u>Henry H. Watson, Pocomoke, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND 10120

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 360

1. PLACE OF DEATH COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Princess Anne</u> LENGTH OF STAY <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Princess Anne Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Harry</u> (First) <u>A.</u> (Middle) <u>McIntire</u> (Last)		4. DATE OF DEATH <u>Oct.</u> (Month) <u>26</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Feb 14 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>63</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James McIntire</u>		14. MOTHER'S MAIDEN NAME <u>Louise Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Dr. George Dunn</u>			

III. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause(a) myocardial rupture

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary occlusion
(c) arteriosclerotic cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH

instantly50 days3 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

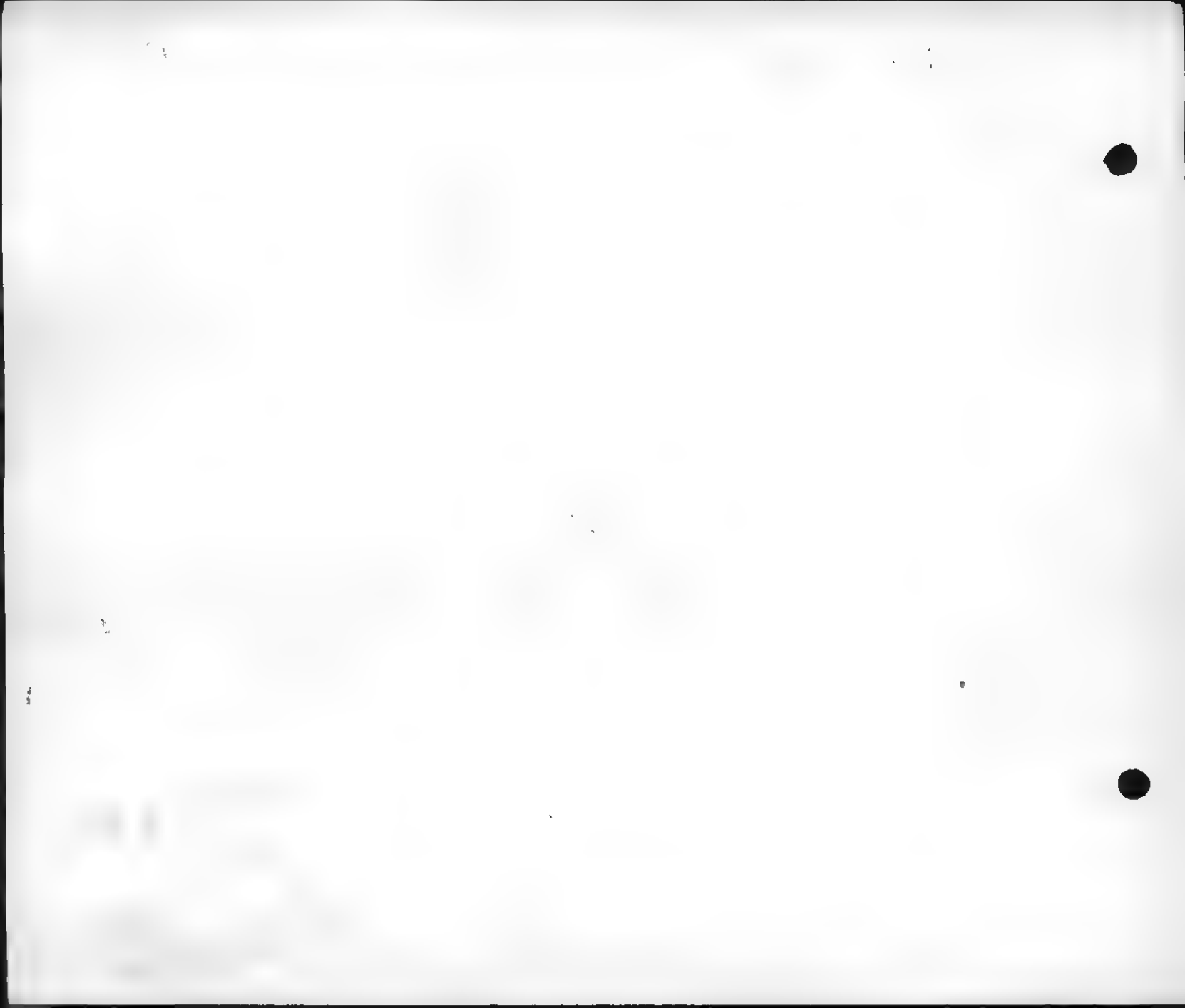
20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5-23, 1953 to 10-26, 1955, that I last saw the deceased alive on 10-21, 1955 and that death occurred at 8:50 A.m., from the causes and on the date stated above.

SIGNATURE <u>George M. Dunn M.D.</u>	(Degree or title)	ADDRESS <u>Princess Anne Md.</u>	DATE SIGNED <u>10-27-55</u>
23. BURIAL CREMATION REMOVAL (Specify)	DATE <u>10/28/55</u>	NAME OF CEMETERY OR CREMATORY <u>John Wesley Cemetery</u>	LOCATION (City, town, or county) (State) <u>Mt. Vernon Md.</u>
DATE REC'D BY LOCAL REG. <u>10/28/55</u>	REGISTRAR'S SIGNATURE <u>R. S. Johnson, M.D.</u>	24. FUNERAL DIRECTOR <u>James Thomas</u>	ADDRESS <u>Princess Anne, Md.</u>



10121

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crisfield		5 days		TOWN Crisfield		37	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 McCready Hospital				Freemantown Rd.			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
HATTIE ANNE MILES		DEATH: October 2 1955		73 yrs		Months Days Hours Min.	
5. SEX: Female		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: Sept. 4, 1882	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Seafood Industry		11. BIRTHPLACE (State or foreign country): Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George W. Sterling				14. MOTHER'S MAIDEN NAME: Caroline S. Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		213-12-5257		Freemantown Rd. Clarence H. Sterling--Crisfield, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						5 days	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Urine Infection, gastric-intestinal type						7 days	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/27, 1955, to 10/2, 1955, that I last saw the deceased alive on 10/2, 1955, and that death occurred at 3 A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
A. N. Ban		Crisfield Md		10/3/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 4, 1955		Lawsonia Cemetery		Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Oct 4, 1955		Barbara S. Adams		Bradshaw & Sons--Crisfield, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10122

10126

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 260

1. PLACE OF DEATH:

COUNTY Somerset MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town)
 TOWN Church Creek Rural LifeHOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY SomersetCITY (If outside corporate limits write RURAL and give nearest town)
 OR TOWN Rural Church Creek, Md.STREET ADDRESS (If rural, give location)
13. NAME OF
 DECEASED:
 (Type or Print)(First) (Middle) (Last)
Shelia Elizabeth Miller4. DATE OF DEATH (Month) (Day) (Year)
October 17 1955

5. SEX:

6. COLOR OR RACE:
col7. SINGLE, MARRIED, WIDOWED, DIVORCED,
 (Specify): Widow8. DATE OF BIRTH:
July 31-19559. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
 yrs. 2 Months 17 Days 17 Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
Maryland12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Lawrence Miller

14. MOTHER'S MAIDEN NAME:

Lela Jones15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
no16. SOCIAL SECURITY No.:
none

17. INFORMANT & ADDRESS:

Lela Jones Kingston Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

490X

Immediate cause

(a) Bronch - pneumonia
 DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
 (b)
 DUE TO
 (c) INTERVAL BETWEEN ONSET AND DEATH
3 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

R. S. JohnsonCHIEF MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER
 ASSISTANT MEDICAL EXAM.DATE SIGNED
Oct 18-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE REC'D BY LOCAL REG.
10/18/55

DATE THEREOF

10/18/55

NAME OF CEMETERY OR CREMATORY

Mt. Carmel Cem.

LOCATION (City, town, or county) (State)

Princess Anne, Md.

REGISTRAR'S SIGNATURE

R. S. Johnson, M.D.

24. FUNERAL DIRECTOR

Arthur H. Jones, Jr.

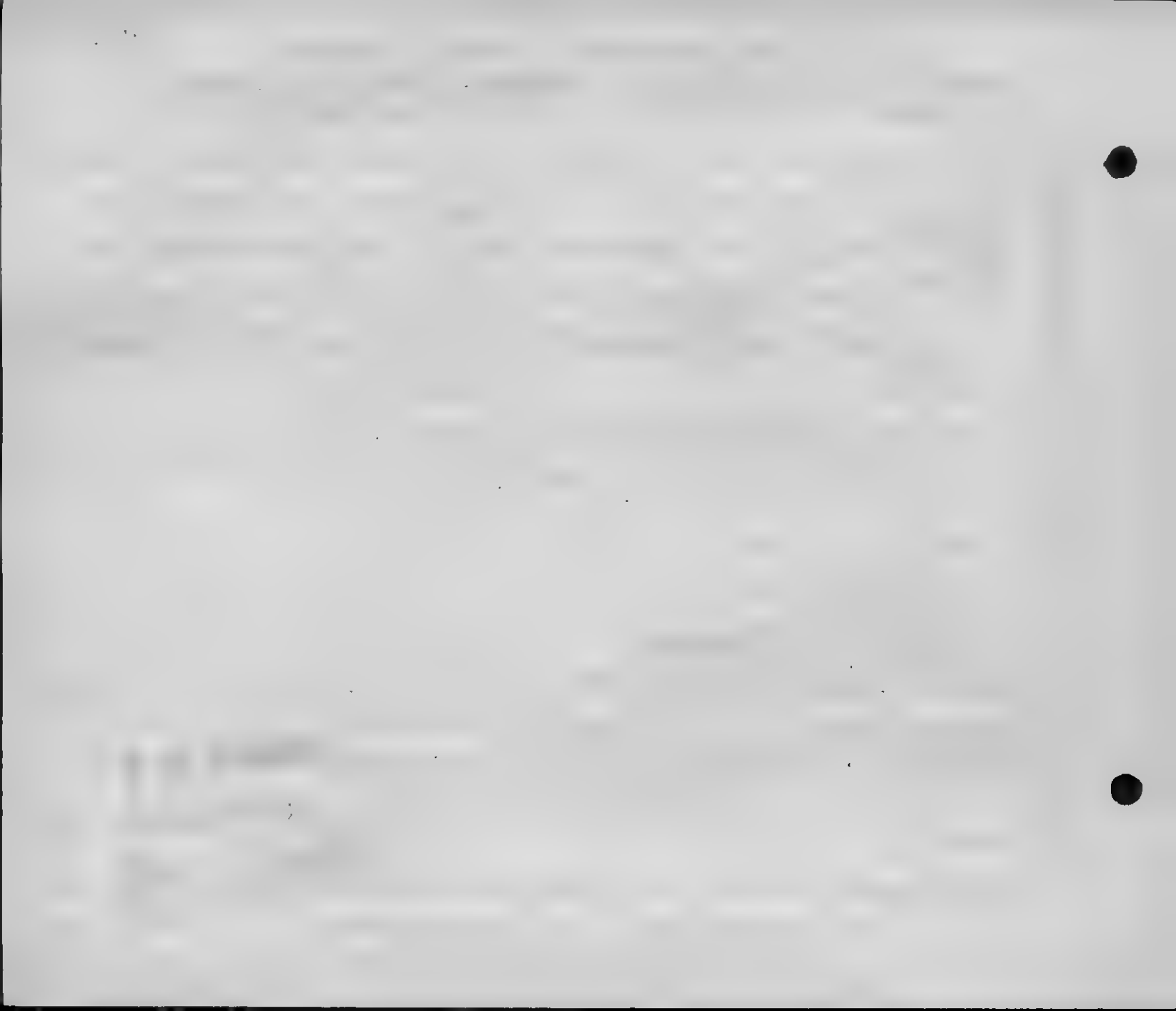
ADDRESS

Princess Anne, Md.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10123 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				10127 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 260					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Somerset</u>		MARYLAND	STATE <u>Maryland</u> COUNTY <u>Somerset</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN <u>Rural Promoke</u>			TOWN <u>Promoke R.F.D.</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) <u>Lottie</u> (Middle) <u>Mobley</u> (Last)			(Month) <u>Oct</u> (Day) <u>29</u> (Year) <u>1955</u>		
5. SEX: <u>Female</u>			6. COLOR OR RACE: <u>W</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>			8. DATE OF BIRTH: <u>April 24-1907</u>		
9. AGE last birthday: <u>48</u> yrs.			10. BIRTHPLACE (State or foreign country): <u>North Carolina USA</u>		
11. BIRTHPLACE (State or foreign country): <u>North Carolina USA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>John Mobley</u>			14. MOTHER'S MAIDEN NAME: <u>Cherie</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.: <u>-</u>		
17. INFORMANT & ADDRESS: <u>Elsie Manuel Promoke md</u>					
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Fractured knee, broken neck</u>					
Antecedent cause(s) (b) <u>Internal organ - Longstanding fracture</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Right and left legs -</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>at home</u>		21c. (City or town) (County) (State) <u>Promoke city Somerset Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct 29-55-730 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>ran in front of car on Highway 13 -</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>R. H. Johnson</u>		M. D. ASSISTANT MEDICAL EXAM. <u>Oct 31-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Wharton Memorial Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Parksley, Virginia</u>		24. FUNERAL DIRECTOR <u>Wharton & Savage Funeral Home-New Church, Virginia</u>		ADDRESS	
DATE REC'D BY LOCAL REG. <u>11-2-55</u>		REGISTRAR'S SIGNATURE <u>R. H. Johnson, M.D.</u>			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

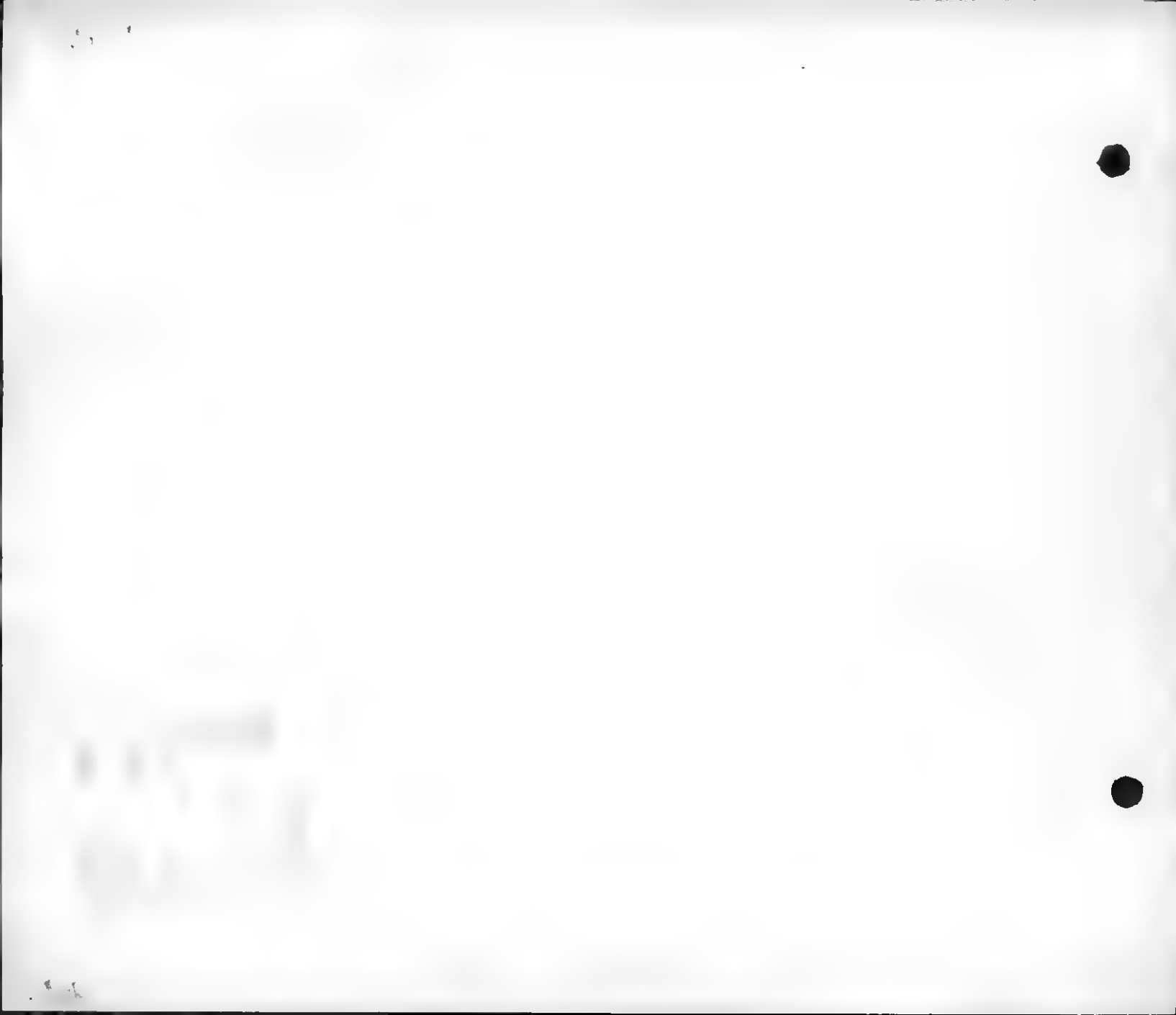
10128

10124

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN	<u>about 4 days</u>	TOWN <u>Farmwood</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>1997</u> <u>Emisfield Hospital</u>			
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Charles</u>	(Middle) <u>W.</u>	(Last) <u>Richards</u>	DATE OF DEATH <u>Oct 31</u> 19 <u>55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Mar 4, 1877</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Malware</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired Malware</u>	
11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George W Richards</u>		14. MOTHER'S MAIDEN NAME: <u>Mary W. Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT'S ADDRESS: <u>Mr. Blanch Ford</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE		(A) <u>Uremia - Cerebral Hemorrhage</u> 3 days	
ANTECEDENT CAUSE (S)		(B) <u>Chronic Int. Nephritis Chronic Myocarditis</u> Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>General Arteriosclerosis & Epilepsy</u> Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 28, 1955</u> , to <u>Oct. 31, 1955</u> , that I last saw the deceased alive on <u>Oct. 31, 1955</u> , and that death occurred at <u>M, from the causes and on the date stated above.</u>			
SIGNATURE <u>George C. Boulton</u>		DATE SIGNED <u>11-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 2nd</u>	
NAME OF CEMETERY OR CREMATORY <u>Ref. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Upper Farmwood, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 1-1955</u>		REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>	
24. FUNERAL DIRECTOR <u>Harry B. Miles</u>		ADDRESS <u>Upper Farmwood Md</u>	



10-25

CERTIFICATE OF DEATH

Reg. Dist. No. 265-

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Crisfield		LENGTH OF STAY (In this place) 3 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marion Station		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 79 McCready Hospital				STREET ADDRESS (If rural give location) Quindocqua Section		/	
3. NAME OF DECEASED: (First) LUCY (Middle) BELLE (Last) TAYLOR				4. DATE (Month) (Day) (Year) OF DEATH: October 13 19 55			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: August 7, 1876	9. AGE last birthday: 79 yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: At Home		11. BIRTHPLACE (State or foreign country): Fairmount, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Dize				14. MOTHER'S MAIDEN NAME: Sarah Adams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No. none		17. INFORMANT & ADDRESS: R.F.D. Quindocqua Mrs. Lillian Dorsey- Marion Station, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Hemorrhage - Thrombosis						4 yrs	
ANTECEDENT CAUSE (B) General Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) Chronic Int. Nephritis & Chronic Myocarditis						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 50, to Oct. 13, 1955, that I last saw the deceased alive on Oct. 13, 1955, and that death occurred at 5:40 A. M. from the causes and on the date stated above.							
SIGNATURE Henry B. Boulton		M. D. Marion Sta. Md.		DATE SIGNED Oct. 14, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 15, 1955		NAME OF CEMETERY OR CREMATORY Fairmount Cemetery		LOCATION (City, town, or county) (State) Fairmount, Md.	
DATE REC'D BY LOCAL REGISTRAR Oct. 14, 1955		REGISTRAR'S SIGNATURE Nellie D. Payne		24. FUNERAL DIRECTOR Bradshaw & Sons--Crisfield, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COLLIER - 671100

BUREAU V. S.

OCT 24 1955

RECEIVED

10112

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Somerset	MARYLAND	STATE Maryland	COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 39 Crisfield	LENGTH OF STAY (in this place) 35 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 39 Crisfield	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Laird Ave.	STREET ADDRESS (If rural give location) Laird Ave.		
3. NAME OF DECEASED: (First) ISIAH (Middle) (Last) THOMAS		4. DATE (Month) (Day) (Year) OF DEATH: October 6 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Aug. 29, 1863
9. AGE last birthday: 92 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): waterman		10B. KIND OF BUSINESS OR INDUSTRY: Seafood Industry	
11. BIRTHPLACE (State or foreign country): Tangier Island, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Lybrand Thomas		14. MOTHER'S MAIDEN NAME: Polly Crockett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Nephritis			
ANTECEDENT CAUSE (B) Generalized Arteriosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Benign Prostatic Hypertrophy Sexual Organization			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-23 , 19 55 , to 10-6 , 19 55 , that I last saw the deceased alive on 10-5 , 19 55 , and that death occurred at 1:20am , from the causes and on the date stated above.			
SIGNATURE A. N. Bar, M.D.		DATE SIGNED 10/6/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 9, 1955	
NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		LOCATION (City, town, or county) (State) Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR Oct. 7, 1955		REGISTRAR'S SIGNATURE Barth S. Adams	
24. FUNERAL DIRECTOR Bradshaw & Sons—Crisfield, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 10 1955

RECEIVED